DESTROYING MYTHS, BUILDING SUCCESS:
EVIDENCE-BASED DEVELOPMENT OF
POLICE CRISIS RESPONSE

by

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Abstract

This paper provides an overview of police interactions with people in emotional or mental health crisis and identifies elements for a successful police response in these situations. The question of the rates of such interactions and the difficulties in determining these rates is discussed, as well as some of the possible contributing factors that affect emotional and mental health in our society. Best practices in police response in these interactions are reviewed, with recommendations for strategies in program, policy, and training development.

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Dedication

To Paul Boyd, Tony Du, and all who have died early and violent deaths due to mental illness or emotional crisis - may you and your families find peace, and may others be saved the same unfortunate fate by learning from yours.

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List of acronyms

EDP – Emotionally Disturbed Person. This is the term most commonly used by police agencies to describe persons who appear to be emotionally or mentally disturbed, whether or not there is a diagnosis of mental illness.

Introduction

Police encounters with persons with mental illness or who are in crisis are complex. The reasons for such encounters are varied, as are the emotional and psychological conditions of the individuals involved, the behaviours exhibited, and the outcomes. A suicidal teen may be experiencing psychosis, emotional crisis, or be high on drugs. A person may be stealing or may just be trying to survive without sufficient support. An assault may be personal or might due to paranoid delusions. All these situations justify police attendance; not all are necessarily criminal or involve mental illness, yet they all might qualify as Emotionally Disturbed Person (EDP) calls, as most police agencies call them. How police see such interactions affects how they respond and what the outcome will be. Police are the first potential point of diversion for persons with mental illness needing help, yet they are also the most potentially dangerous point for the person with whom they are interacting because police have authority and weapons.

Police interactions with emotionally disturbed persons is a pressing issue in criminal justice and in the public realm these days, not least because of highly publicized police shootings of individuals during such encounters – often within a matter of a few minutes of police arriving on scene. The Vancouver deaths of Paul Boyd in 2007 (http://www.cbc.ca/news/canada/british-columbia/b-c-police-shooting-video-sparks-calls-for-new-probe-1.1159285), of Tony Du in 2014 (http://www.cbc.ca/news/canada/british-columbia/phuong-na-tony-du-bc-coroners-service-public-inquest-1.4407469), and of Sammy Yatim in 2013 in Toronto (http://nationalpost.com/news/toronto-police-criticized-for-shooting-of-cornered-man-

brandishing-a-knife-on-empty-streetcar) are but a few of the most public police shooting deaths of emotionally disturbed persons in Canada.

An intersecting issue is the reportedly high rates of mental illness among the inmates of jails and prisons, raising concerns that people with mental illness are being criminalized in the justice system rather than being diverted to needed mental health services (Fazel & Danesh 2013; Prins 2014). Police – as the first contact an individual has with the criminal justice system – represent the first opportunity to divert mentally ill persons to the health system rather than the criminal justice system. Involvement in the criminal justice system brings negative consequences: a criminal record may create barriers to employment, housing, and convictions may lead to imprisonment and increased risk of victimization within that setting (Bitz, Wollf & Shi, 2008; Tschopp et al., 2011). These consequences are significant for those who already face challenges due to their illness.

The commonly held assumption that deinstitutionalization alone is the cause of the increase in these interactions is unsupported (Trestman et al., 2007; Pinta 2009; Raphael & Stoll 2013; Mulvey & Schubert, 2017) and circumvents a deeper assessment of other contributing factors and the need to address them. At the same time, police agencies must accept that this is part of their work and must approach these interactions with the tools and attitudes necessary to resolve them successfully. Traditional police culture not only rejects this type of work as being outside of their mandate, but also can perpetuate the stigma, misconceptions, and fear of mental illness. This has a significant impact on how police may engage with emotionally disturbed persons which can sometimes lead to criminalization, injury, and death.

This paper will first review the rates of police contacts with emotionally disturbed persons, discuss the potential causes for increases in mental illness in our society, and examine some of the myths that affect how police behave during these interactions. The latter part of the paper will review some current models of police response programs and will suggest a process for developing an effective and evidence-based program for police response to emotionally disturbed persons.

The Issue: Increased Interactions Between Police and Persons in Crisis

Police agencies in North America and elsewhere have experienced an increase over the past forty years in encounters with persons with mental disorders (Charette, Crocker & Billette 2011; de Tribolet-Hardy, Kesic & Thomas 2015; Watson & Fulambarker 2013). These interactions may arise through chance encounters, crisis calls, complaints, public disturbance, crime, suicidality, requests for apprehension under the *Mental Health Act* of a person with apparent mental illness who may pose a danger to self or others, or a "recall" to a psychiatric institution for similar reasons (Watson, Angell, Morabito & Robinson, 2008).

To many police, the increasing number of EDP calls is frustrating; police officers are usually under pressure to complete calls quickly, and mental health encounters consume time and resources that they believe should be focused on what they consider "core" law enforcement activities (Godfredson, Thomas, Ogloff, 2011; Lurigio and Watson, 2010). Mental health calls can be more challenging and time consuming than other calls, particularly *Mental Health Act* apprehensions which require police to transport the individual to hospital and wait for a doctor to conduct an assessment for psychiatric

admission. On the other side of the equation, people with mental disorders and their supporters have concerns about police response to mental health calls and in many cases would prefer to deal with family or health professionals rather than the police (Watson & Morabito 2008; Livingston et al., 2014). Regardless, no matter how effective a response the mental health system has to persons diagnosed with mental illness, the police will always have to engage in such encounters in the course of their work. There will always be those individuals who have not received a diagnosis and/or who are experiencing a first break with reality, as well as those who are experiencing severe emotional distress outside of the realm of diagnosed mental illness. The police are often the first to be called because they are available 24/7, they are easily accessible, and sometimes there are safety issues involved that prevent civilians from engaging. Police alone are also provided the authority under the *Mental Health Act* (sec. 28) to apprehend a person to take them to a designated facility for a mental health assessment.

A review of the rates of police encounters with EDPs is an important first step in understanding the pattern of police officers' involvement with EDPs. Comprehension of this issue can be further enhanced through a review of rates of mental illness in society, along with a discussion of the possible reasons for apparent increases in such encounters.

Rates of Contact

It is difficult to find reliable data on the rate of mental health related police encounters; there does not appear to be any standardized framework for the collection of such data, if police agencies collect this data at all (Boyce, Rotenberg & Karam, 2015). There are also several confounding factors which challenge the reliability and transferability of this type of data. First, definitions of mental disorder are not always

consistent or consistently applied (Boyce et al., 2015; Livingston, 2016), making it difficult to compare or combine data in a meaningful way. Secondly, capture of this type of data by police agencies is inconsistent, and sometimes the methodology is highly suspect (Boyd & Kerr, 2015). The Vancouver Police Department has claimed that "31% [of recorded police attended calls in Vancouver] involved a person who the attending member believed was suffering from poor mental health to the extent that a police response was required" (Wilson-Bates 2008, p. 11). This figure rose to 42% in District 4 which includes the downtown eastside and the poorest city neighbourhoods but remained a high 29% in even the wealthiest area, District 4. This data must be viewed with caution: data collection methods were not scientifically rigorous, and the rates indicated are significantly higher than those reported elsewhere. For example, data from the United States shows national rates of seven percent (7%) in urban centres (Deane et al 1999; Reuland et al 2009), or ten percent (10%) generally (Watson et al. 2010). Canadian study data is regrettably sparse: one study conducted in Montreal, Quebec set the rate of mental health involved police calls at three percent (3%) (Charette, Crocker & Billette, 2011). While the data collection methodology in this study was relatively rigorous (police database records and algorithm), the sampling method had limitations, being based on only three random days in a year.

There is some support for this latter figure, however. Data collected during the Statistics Canada 2012 Canadian Community Health Survey – Mental Health (CCHS-MH) provides statistics from the other side of the fence: the data indicated that approximately eighteen percent (18%) of Canadians reported coming into contact with police on duty in the previous year either as a victim of or witness to a crime, for a traffic violation, arrest, or for personal or family member issues involving emotional, mental health, or substance use

problems (Boyce, Rotenberg & Karam 2015). Of those five million Canadians constituting the 18%, about one in five (18.8%) met the criteria for a diagnosable mental or substance use disorder – which is three percent (3%) of the surveyed population as a whole. The criteria used in the survey were adopted from specific modules from the World Health Organization – Composite International Diagnostic Interview, a standardized instrument for the assessment of mental disorders and conditions according to the Diagnostic and Statistical Manual, Fourth Edition (DSM-IV). Respondents were asked about symptoms experienced and the types of behaviours they engaged in within the previous year; based on their responses, respondents were classified in terms of whether they met the criteria for a specific mental or substance use disorder. While this methodology may provide better accuracy in terms of rates of contact between persons with mental illness, its usefulness is limited as it does not reflect whether the officer was aware of mental illness, and whether that affected the interaction and the outcome. A further limitation is that survey excludes some significant portions of the population, such as persons living on reserves and other Aboriginal settlements, full-time members of the Canadian Forces, and the institutionalized population; potentially skewing the rates.

An alternative perspective sheds some light on the frequency of reported police contacts by persons diagnosed with mental illness. A recent systematic review of peer-reviewed studies from western countries (primarily the United States) triangulated data on three types of contacts that persons with mental disorders typically have with police: via arrests, as a pathway to mental health care (that is, contact with police while trying to access mental health care), and through calls for service (Livingston, 2016). The findings from the synthesized data suggested that one in four (25%) persons with mental disorder

have been arrested, one in ten (10%) encountered police in their path to mental health care, and one in one hundred (1%) police dispatches were flagged as involving a person with a mental disorder. While the studies reviewed used rigorous methodology, issues regarding recognition and recording, reporting practices, and the casual nature of many encounters which are resolved informally likely resulted in some degree of under-reporting (Livingston, 2016; Charette et al., 2011). Different definitions of mental illness, assessments of mental illness by non-professionals (dispatchers, police officers, fieldworkers), and different objectives for each study may also be confounding factors that skewed the overall results.

Standardization of definitions and data collection methods would provide a clearer and deeper understanding of the number, type, context, and outcomes of these police interactions, but there are still challenges with these standards. In 2007 the Canadian Centre for Justice Statistics (CCJS) consulted with criminal justice stakeholders to address the need for data collection on persons with mental illness in the criminal justice system. In the policing context, identified issues included the need for a standardized definition of "mental illness", the problems with creating one, as well as the need for standardized forms (Sinha, 2009). The Canadian National Police Mental Health Liaison subcommittee of the Canadian Association of Chiefs of Police favoured the use of criteria from the Diagnostic and Statistical Manual for Mental Health Disorders (DSM) except for disorders such anti-social personality disorder, arguing that this disorder is criminogenic by nature (http://www.statcan.gc.ca/pub/85-561-m/2009016/section-b-eng.htm#n1. Using the formal DSM for defining such police encounters is problematic, however. Police are not diagnosticians and cannot therefore determine whether an individual would fit such a

definition; it is not within their purview to make this determination and circumstances do not often permit sufficient time for officers to make such an assessment. The value of the definition depends on the purpose for which the data is to be used: determining rates of interaction between police and persons with mental illness is a different context than determining rates of police interactions where mental health is an issue in the interaction.

Many, if not most, police agencies operationally use the collective term "Emotionally Disturbed Person" (EDP) for calls or interactions involving someone having a behavioural, mental, or emotional issue or crisis (Sinha, 2009). This term recognizes the behavioural cues relevant to the police response without defining whether the emotional disturbance is transitory or long term, and without attributing cause for the behaviour. This term has the benefit of responding to the issue at hand without implying an illness or definition but is limiting in that it does not define the strictly "mental disorder" subset within that category which can be problematic for research and statistical purposes. The term and definition used must depend on the issues being analyzed: in looking at police encounters, the EDP term is most appropriate, but when looking at issues of criminalization, the DSM is more appropriate as it is specific to those with a diagnosed mental disorder.

There are several confounding factors affecting perceived and even identified rates of contact between police and persons with mental illness. Until methodologies improve and provide a clearer picture of the factors which influence an officer's conclusion that mental illness is apparent or involved in an interaction with an individual, there is no way to determine with any real certainty the rates of such contacts. Engel and Silver (2001: 236) correctly identify an important consideration: "a key mediating variable in the criminalization hypothesis is officers' perceptions of mental disorder, regardless of

whether mental disorder is present in a clinical sense. If the goal is to understand officers' decision making, then officers' perceptions of mental disorder are more relevant than are classifications based on clinical criteria.

In general, this paper will use the terms or definitions used in specific studies, but in a general sense the category of interest here is police encounters with "emotionally disturbed persons" rather than with "individuals with mental illness", as the focus is on police response to crisis situations rather than on encounters with persons with mental illness, per se. The terms "mental illness" and "mental disorder" are interchangeable in the context of this paper and form a subset of the broader term "emotionally disturbed".

Reasons for Increased Encounters

Contributing reasons for possible increases in police encounters with emotionally disturbed persons are not well understood although, as will be discussed in the following section, several contributing factors have been identified. Often the cause is attributed to the closing of secure psychiatric facilities, known as the deinstitutionalization movement, without consideration of other possible contributing factors. Sociological changes have also had significant impact on mental health and wellbeing in our society generally. Globalization, immigration, urbanization and isolation, economic disparity, and poverty are likewise factors affecting the mental health of the population and may be relevant to increasing levels of emotional distress and active mental illness, which may contribute to increasing rates of police encounters with persons in crisis.

Deinstitutionalization

Commonly professionals and academics attribute an apparent increase in community visibility and police encounters with persons with mental disorder to the de-institutionalization movement which saw the release of persons from custodial psychiatric institutions to community care (Abramson 1972; Carroll 2005; Harcourt 2006; Lamb, Weinberger & Gross 2004; Torrey, 1997). The movement to de-institutionalize the mentally ill began in the 1950s and was driven by several factors. Development of more effective psychopharmaceuticals and psychosocial rehabilitation practices that helped to control more serious symptoms of mental illness, combined with a new awareness of the rights of patients and the negative impacts of institutional life, as well as the high costs of institutionalization led policymakers to consider other solutions to managing people with mental illness (Morrow, Dagg & Manager, 2008).

Higher rates of police contact with persons showing symptoms of mental illness are sometimes inferred from rising rates of mental illness among correctional inmates. Better quality and usage of mental health assessments in correctional facilities has provided some significant data on the high rates of mental illness among those incarcerated in correctional facilities. This, coupled with indications of insufficient increases in mental health services and supports in the community for those released from psychiatric institutions, has prompted a suggestion that the de-institutionalized are in a sense trans-institutionalized, moving from mental health institutions to correctional institutions (Abramson 1972; Early, 2006; Harcourt 2006; Mulvey & Schubert, 2017). Yet some academics (Prins, 2011; Reuland et al., 2009) consider this a simplistic explanation that is not fully supported by evidence, noting that:

> {s]ome observers suggest that deinstitutionalization is a main cause of the increased number of people with mental illnesses in contact with the criminal justice system. In fact, no study has definitively shown a transition of this population from mental health institutions to jails and prisons. Other trends in criminal justice and mental health policy—for example, higher arrest rates for drug offenses and underfunded community-based treatment—are likely to account for this population's increasing contact with law enforcement, courts, and corrections.
>
> (Reuland et al., 2009, p. 4)

Studies from the U.S. have shown that there was not a major transfer of individuals from state hospitals to jails or prisons and that formerly hospitalized people are neither demographically nor clinically similar to people with mental illness who are held in jails and prisons (Trestman et al., 2007; Pinta 2009). In fact, less than twenty percent of the recent growth in incarceration rates may be attributable to an increase in the number of mentally ill individuals who might formerly have been treated in hospitals (Raphael & Stoll 2013), and there is no evidence showing a wholesale shift from one type of institutional care to another (Mulvey & Schubert 2017).

Possible Contributors to Increased Rates of Emotional Disturbance

If increasing numbers of police encounters with EDPs are only partly attributable to deinstitutionalization then other explanations must exist for this phenomenon, or at least contribute to it. Societal changes over the past fifty years may play also a large part in the rising levels of mental illness. Increased mobility and migration, urbanization, social isolation, and the rise of neoliberalism and economic inequality may all play some part in increasing levels of emotional stress and distress and increasing signs of mental disorder in our communities. Possible contributors to this phenomenon need to be explored to better understand and address these issues and how they affect the issues and rates of increasing police interactions with persons with mental disorder or emotional distress.

a. Globalization and Mobility

Globalization trends and conflicts throughout the world have led to an increase in Canada's immigrant population, which includes large numbers of refugees. Since 2003, about 214 million individuals worldwide have been identified as international migrants; this represents a substantial increase of forty percent (40%) from 2000. In fact one in thirty-three people in the world's population is now considered a migrant (International Organization for Migration, 2013). The migration process itself can impart significant stressors which contribute to psychological problems among migrants; other mental health impacts that follow the migration itself include isolation, low socio-economic status, goal-striving stress, changing lifestyles, discrimination, and cultural change (Daoud, Haque, Gao, Nisenbaum, Muntaner & O'Campo, 2016; Kirmeyer, Narasiah, Munoz, Rashid, Ryder, Gudzer … & Pottie, 2011).

Among the immigrant population, refugees are at substantially higher risk for several psychiatric disorders as compared to the general population, with up to 10 times the rate of post-traumatic stress disorder, as well as elevated rates of depression, chronic pain, and other physical complaints (Beiser, 2005; Beiser 2009; Mann & Fazil, 2006). There is also strong evidence indicating that some groups of migrants have an elevated incidence of psychotic disorders after migration (Coid et al., 2008; Jarvis, 2007; Smith et al., 2006).

It is necessary to recognize the impact of immigration – particularly of those seeking asylum – on the changing rates of mental disorder in Canada today. That is not to imply that immigration and refugee policies should become more restrictive, but rather identifies the need to recognize and ameliorate the factors in migration and refuge seeking which negatively affect mental health. While not all such individuals will face encounters with

police it is likely that a significant number will (Livingston, 2015). This is an area which has been poorly researched in Canada, and merits further study to improve understanding and develop appropriate responses (Jarvis, 2007).

Social Isolation

More people today live in urban and developed areas than not, primarily due to economic migration (Davis & Schaub, 2005; Gupta & Bhugra, 2009; Luo & Stone, 2017). Both internal and external migration produce changes in stressors and social support networks making individuals more vulnerable to psychological factors (Gupta & Bhagra; Luo & Stone). Communities in rural areas (whether in Canada or elsewhere) may provide more familiarity and support than the often impersonal and alienating culture of the city, where there may be more people and better access to services, but where social isolation tends to be greater than in smaller communities (Schomerus, Angermeyer, Bebbington, Azorin, Brugha & Toumi 2007).

Social isolation and loneliness are especially prevalent among people with mental illness (Elisha, Castle, & Hocking, 2006; Linz & Sturm 2013), in part due to negative attitudes toward mental illness, stigma, and shame which lead to isolation and alienation of those living with it, making social rehabilitation more difficult (Erdner, Magnusson, Nystrom & Lutzen 2005). At the same time, social isolation is associated in general populations with emotional distress, anxiety and depression, and with exacerbation of latent mental illness and psychosis (Hawkley & Cacioppo 2010; Smyth, Siriwardhana, Hotopf, & Hatch, 2015).

Economics and Neoliberalism

The rise of neoliberalism and the economic 'restructuring' of the 1980s meant that income equality widened between the "haves" and the "have nots"; increased rates of unemployment and underemployment resulted in widening gaps of income, social status, and class. Socioeconomic disadvantage (evidenced by low education, unemployment, and poverty) and low levels of social capital in rich nations have been associated with mental illness (Pickett, James & Wilkinson, 2006). It might seem logical that these are linked; the question is how they are linked and whether any has a causal influence over another.

Greater levels of income inequality are also linked to higher prevalence of mental illness, and more so in richer countries (Pickett, James & Wilkinson, 2006), indicating that not only poverty itself but *relative* poverty contributes to mental illness. Social stress to compete, to advance, to have material goods and money, promoted widely in western society, may well be a relevant factor in the increases of mental illness and emotional distress when it is not possible for an individual to achieve these goals. Higher rates of income inequality lead to differences in levels of social trust and cohesion, negative views of one's status and worth, and perceived loss of control (Marmot, 2001). These factors can readily contribute not only to mental illness, where stressors lead to the exacerbation of symptoms, but to emotional crises among the general population as well.

Community Characteristics

Residence in deprived neighbourhoods is also negatively associated with change in mental health, even after adjustment for individual socio-economic risk factors and transitions in life events; however, this effect is significantly lower in high social cohesion

neighbourhoods (Fone et al., 2014). As stated above, economic inequality has a negative impact on mental health. Those who live in urban environments – particularly in socially disorganized neighbourhoods – have a higher risk for mood and anxiety disorders and schizophrenia (Lederborgen et al., 2011). Environmental factors of noise and lack of green space (Wood, Foster & Bull, 2017), poverty, residentially unstable neighbourhoods, dense and diverse populations, high crime rates, and social disorganization can lead to substantial stress and an increased vulnerability to mental illness symptoms (Anakwenze & Zuberi, 2013). Neighbourhood disorder can have profound and chronic effects on mental stress and distress (Mckenzie, 2008; Latkin & Curry, 2003) and may cause heightened psycho-physiological stress responses, which in turn can affect cognitive functioning, aggressiveness, impulsiveness, and anger (Harding, 2010). Exposure to violence (as an observer, or worse, as a victim) can lead to depression and social disengagement (Marans, 1995) and isolation, which in itself can contribute to mental illness, as referenced above. A combination of social disorganization, poverty, substandard housing, and unemployment can lead to feelings of powerlessness, depression, anxiety and stress, and more serious mental health impacts (Marans, 1995) which can impede efforts to change one's circumstances for the better.

A Multitude of Societal Factors

Addressing the factors in our society that contribute to mental and emotional distress requires investment in developing livable and inclusive communities, lessening the fiscal divide and promoting greater economic parity, and ensuring that basic needs are met in a respectful way. Persons with mental illness living in the community, whether previously institutionalized or not, need to be accepted and invited to participate in that

community (Ennis, McLeod & Watts, 2014). Successful community living for such individuals requires that basic needs such as housing and living expenses are met, and that treatment for mental illness and addiction, psychosocial rehabilitation and life skills such as budgeting, self-care, planning, financial management and social engagement are accessible.

This section has reviewed some of the sociological and contextual factors contributing to increasing signs of mental illness and emotional distress in western societies. Police as the guardians of social order are on the front line in responding to the disorder and crisis that can arise with mentally ill and emotionally distressed persons in our society. While some are resistant to this role, it does fall within their professional domain as first responders to issues of social disorder.

Perceptions of Police and Persons with Mental Disorders

Perceptions of those involved in police-mental health encounters about the incident and the other player(s), are germane to clarifying the factors and dynamics at play in a general sense for each side of the equation. While an overview of perceptions will not necessarily explain interactions in individual encounters, knowledge of these general trends in perceptions can inform how we might improve approaches to and outcomes of these interactions generally.

Evidence indicates that both persons with mental illness and police tend to anticipate potential for violence in these encounters. Police officers tend to perceive encounters with persons with mental illnesses as particularly dangerous according to some studies (Margarita, 1980; Ruiz & Miller, 2004; Watson, Corrigan & Ottati, 2004). This

expectation of danger may cause police to approach these encounters in ways that escalate the crisis and resistance of the subject, to which they then respond with physical force; in fact subject resistance is one of the most consistent predictors of police use of force (Klahm & Tillyer, 2010; Morabito et al., 2014), even if the resistance was merely verbal (Johnson, 2011). The latter study also found that persons with mental illness are more likely to resist arrest, and to possess a weapon, although it is unclear how much the former might be attributable to a greater likelihood of officers to view common objects (such as a piece of wood, a screwdriver, or a chair) as a potential weapon when dealing with persons with mental illness. Several recent studies indicated a greater tendency for use of higher levels of force – including weapons - by police in encounters with persons with mental illness (Mulvey & White, 2014; Rossler & Terrill, 2017).

Police perceptions that an individual is high on drugs other than alcohol also correlates with a higher use force (Garner, Maxwell & Heraux, 2002; Johnson, 2011; Kaminski, Digiovanni, & Downs, 2004; Klahm & Tillyer, 2010; Paoline & Terrill, 2004). Officers may find it difficult to distinguish symptoms of mental disorder from symptoms of drug intoxication which might result in higher use of force (Alpert, 2015). As well, substance use disorders commonly co-occur with mental disorders; many persons experiencing mental illness resort to illicit substance use as a form of self medication (Lev-Ran, Imtiaz & Le Foll, 2013; Schlosser & Hoffer, 2012). The combination of mental health symptoms and substance intoxication may affect police response, although the impact of this combination has not been specifically researched.

Police Perceptions: Truth vs. Fiction

How police see these encounters and their general perceptions about mental illness are highly relevant to how these encounters unfold. A police perception that these encounters are dangerous is not supported by available evidence: the most recently published government statistics indicate that only two and a half percent (2.5%) of police homicides between 1961 and 2009 occurred while apprehending a psychiatric patient. (Statistics Canada, 2010).

The perception itself can, however, lead to serious consequences for the persons with whom they interact. While there is no formal accounting of such deaths in Canada, the CBC reported on journalist Yvette Brend's research findings that coroner inquest records between 2004 and 2014 show that while the number of police involved shootings in Canada remained fairly static, the percentage involving persons with mental crisis grew to forty percent (40%) of the total number within that time frame (http://www.cbc.ca/news/canada/toronto/new-documentary-explores-lethal-use-of-force-on-mentally-ill-1.3259731). Statistics from the U.S. show similar rates: rates from 2015 show that twenty-five percent (25%) of all fatal police shootings nationwide that year involved persons in emotional crisis (Steadman & Morrissette, 2016; Watson, Compton, & Draine 2017).

Aside from police-involved deaths requiring a coroner's inquest (*Coroner's Act* SBC 2007 Chapter 15), statistics on police use of force in British Columbia and nationally are not currently published. While police forces in British Columbia have been required since 2010 to complete Subject Behaviour/Officer Response (SBOR) reports for every use of force incident and make these available to the Police Services Division of the British

Columbia Solicitor General's Ministry, they are in formats (text or PDF) which cannot be analyzed without transcription into a different database requiring significant time-consuming data entry, and this has yet to happen (Bard 2018). There are other challenges currently in the collection and analysis of data: incomplete and incorrect forms, and the multiple manual processes required for accessing data means data gets lost (Hoffman, personal communication, March 18, 2018). The lack of published data prevents an analysis of the context and factors involved in police use of force which could inform research and recommendations for police policy, practice, and training as well as public perceptions and accountability.

Persons with Mental Illness: The View from the Other Side

Few studies have reported on perceptions of police encounters by persons with mental illness; a search of the literature yielded only three published studies in the past twenty years examining this perspective (Jones & Mason 2002; Livingston et al. 2014; Watson et al 2008). Two common themes run through the narratives of the persons interviewed in these studies. The first is the desire of persons with mental illness to be treated with respect by police and have their voice heard, elements of procedural justice are very important. The second is that even while feeling that police often used more force than necessary subjects were appreciative of every indication of kindness, care, and respect they received, and many were forgiving of police actions, holding a common belief that police were just "doing their job".

The studies also show some variation in participants' perceptions of police, depending in large part on the behaviour and attitude of the officer(s) involved and the expectations of the participant. The earliest study, comparing treatment by police and

mental health staff in the U.K., found that participants were resigned to the actions and attitudes of police and had no expectation that they would act differently than they did in apprehending them, but did have greater expectations from mental health staff and so were less satisfied with the treatment they received from them (Jones & Mason, 2002).

Livingston et al. found that half of the study participants in this Vancouver based study rated their most recent interaction with police as generally positive, but 37% considered that excessive force had been used by the police in previous interactions (Livingston et al., 2014). This may be in part due to the participant self-selection process, which might exclude those with less capacity to participate for reasons of illness or lifestyle, or lack of connection with services where participants were invited to participate in the study.

The Watson study also found a reasonably high rate of satisfaction, but the authors question whether this may be in part because of expectations of worse treatment, as participants shared generally negative perceptions and expectations of police officers. Personal or second-hand knowledge of negative experiences, distrust of police, and the perception that their status in the community was tenuous made subjects feel vulnerable in such encounters. Participants in this study reported fears of being killed, being falsely arrested, and of police brutality - relief at not experiencing these outcomes made them consider the encounter to be "positive" (Watson et al. 2008, p. 452). Participants in this study also reported verbal abuse and disrespectful attitudes, fast and forceful handling without being given time to respond, harsh and physically abusive treatment, and unnecessary force.

These studies are limited by the small size of participants (Jones: n=16, Livingston: n=60, Watson: n=20) and the use of a single community location preventing generalizability of results. Participant selection for such studies is challenging in terms of criteria and recruitment, ethics considerations when dealing with vulnerable populations, and trying to ensure some measure of representativeness of the selected population. Even so, these studies showed some similar perspectives across three different western countries: United Kingdom (England), Canada, and the United States, respectively. Perhaps the most noteworthy finding across the three studies is the importance of procedurally just behaviours on the part of officers in these interactions. Procedural justice in this context generally requires treating people with dignity and respect, providing them with opportunities to tell their side of the story, and appearing concerned for their welfare (Watson & Angell, 2007)

Summary

Research on how both police and particularly persons with mental illness or in emotional distress perceive their interactions is extremely limited. A better evidence base in this area would provide useful knowledge in developing better approaches. Increasing police understanding regarding the danger or lack thereof in encounters might foster a better response from officers and reduce police use of force. Better understanding of how individuals perceive police, how they respond to police, and what they want or need from police in these encounters could help to make these encounters less dangerous and more cooperative.

Building an Effective Model of Police Response to Emotionally Disturbed Persons

To provide the best response to emotionally disturbed persons, police agencies must approach the issue in a systematic and informed way. While there is a concerning deficit in evaluation evidence to demonstrate a comprehensive "best practice" in this area, there is now some evidence showing positive impact for elements of current practice, and evidence of other factors which can inform efforts to improve police response in these encounters. While there is no "one size fits all" program that will meet the needs of every community, a systematic development of a comprehensive program guided by evidence will provide the best available solution to meet those needs.

Crisis Response Models

A variety of crisis response models have developed over the years, each of them has advantages and limitations. Not every model is the right fit for every community, for a variety of possible reasons that include community size, resources (both fiscal and other), availability of partners, sources of leadership and stability, and community need. This section will review a sample of most utilized models for police response, with brief outlines of structure and primary elements as well as some discussion of evaluation evidence of the model where available.

Comprehensive Advanced Response

In this model, all front line and supervisory officers are mandated to take a forty-hour training course in advanced mental health and crisis de-escalation response (Consensus Project Report 2002; Watson & Fulambarker 2012). While it is beneficial for all police officers to gain knowledge of mental health crisis issues, there are limitations of

this model which relies only or primarily on training alone. One issue is that all officers are for the most part engaged in regular police duties and have less opportunity to practice and hone the very different (and often antithetical) set of skills and behaviours necessary for effective de-escalation of mental health crisis. Another potential downside of this model is the assumption that all officers have the same capacity and innate characteristics (for example good communication skills, patience, empathy, and self-control in the face of difficult and possibly threatening behaviours) to make them effective in crisis de-escalation. Finally, if the program is simply training for all officers, the lack of collaboration with other sectors (primarily mental health, hospital, and other health services) limits knowledge about procedures and protocols, services and possible alternative dispositions, and limits collaborative solution building for systemic issues (Winters, Magalhaes & Kinsella 2015). Working in collaboration rather than in silos breaks down barriers and provides better continuum of care for the individual, providing mutual support for the police and health services involved.

This model of providing advanced training to all officers has been implemented in some locations, including Vancouver, B.C. which provided a four day in-house training program to all patrol officers between 2002 and 2011, when it was replaced by the lower level provincially mandated Crisis Intervention and De-escalation training (Weibe, 2016). Concerns expressed about this model of providing only training include potential negative impact of resistant officers on others during training, compromising of training quality due to numbers, unsuitability of some officers for this type of work, and the watering down of specialization that provides ongoing skill development for selected officers who have shown a desire for, commitment to, and the necessary skills to do this work well (Cochran,

citinternational.org/resources/Documents/Position%20Statement%20on%20Generalist_Specialist%20Model.pdf).

Comprehensive training may be appropriate in a small remote police agency in which all officers have regular interactions with persons with mental disorders, but no capacity for a specialized response. However, this model is best supplemented by, at a minimum, access to mental health professionals such as psychiatrists, psychologists, psychiatric nurses, or social workers with advanced training in mental health to provide advice to on scene officers, and to provide ongoing educational support in a formal or informal manner.

Collaborative Mobile Response

Mobile response models usually involve the pairing of an officer with a clinician (mental health worker, social worker, or psychiatric nurse) in a mobile unit who may be dispatched to a scene requiring assistance with an individual experiencing mental or emotional health issues. Evaluation evidence indicates this model has shown an increase in service utilization by clients, reduced on-scene and "down" time for police, resulted in a preference among clients for a joint response model, improved emergency department diversion, increased direct access to inpatient mental health services, improved interagency collaboration, and enhanced knowledge transfer (Kisely et al., 2010; McKenna, Furness, Oakes & Brown 2015). Knowledge transfer in this context provided both police and mental health practitioners better understanding of roles, and police were able to better understand behaviours arising from mental illnesses and to learn through seeing mental health practitioners' communication techniques for effective de-escalation. This

model is popular in British Columbia and often used for follow-up with an individual who has had police contact and about whom there may be an ongoing concern. Examples locally include South Vancouver Island's Integrated Mobile Crisis Response Team (IRMCT), Vancouver's Car 87/88, and Surrey's Car 67.

The limitations of this model may include some lack of coverage as resources usually limit the number and hours of mobile units, and the inability to respond to incidents with potential for violence, due to liability issues respecting the presence of the civilian mental health/social worker (Vancouver Police Department response to BC Coroner Inquest 270.0809 (Boyd, Paul Glenn) Recommendations, 2011). Another limitation is due to capacity issues: with one or two mobile units, the ability to respond to multiple calls within a given time period is compromised (Steadman, Deane, Borum & Morrisey 2000).

Co-responding Mental Health Professionals

In this model, mental health or social workers working either in the police agency or in a mental health agency respond to calls from on-scene officers to assist in de-escalation and service connection for individuals in mental health crisis. Qualitative evaluation research has shown satisfaction with this model in some locations (Saunders & Marchik 2007).

The main limitation of this model involves coverage issues outside of regular work hours of the service involved. Where there is 24-hour coverage, it is usually through one worker being on call on a rotating basis. Significant delays in attendance were noted where there were limited number of available co-responders serving an area. Another potential

limitation relates to lack of regular interaction and collaboration between agencies where mental health workers are not embedded in the police agency (Steadman, Deane, Borum & Morrisey 2000). Evaluation of this model is very limited.

Memphis Model Crisis Intervention Team

The Memphis Crisis Intervention Team (CIT) is often erroneously defined by the forty-hour training component included in this program. The true Memphis CIT is much more than that; in fact, the motto of CIT International is "More than just training" (http://citinternational.org/). This is perhaps the most widely implemented model among law enforcement agencies, with more than 3,000 existing programs internationally. CIT is designated as an Evidence Based Practice for officer-level cognition and attitudinal outcomes, though more evaluation and research is needed to provide an evidence base with respect to other outcomes (Watson, Compton & Draine 2017).

The basic components of the Memphis Model Crisis Intervention Team model include:

- Voluntary application by regular patrol officers and suitability selection process;
- Advanced training in mental health/crisis de-escalation (comprehensive 40 hours);
- Core of 20% of regular patrol designated as specialist CIT officers with 24/7 coverage for dispatch to mental health calls;
- Dispatch training in mental health crisis identification and information needs for attending officers;
- Access to 24/7 on demand mental health emergency care with a no-refusal policy for CIT officers and minimal turnaround time; and
- Community collaboration and partnership with mental health and other community services (hospital, substance use detox and treatment, housing, income, psychosocial rehabilitation), persons with lived experience, advocates, government, criminal justice system, and universities.

Considering how widely this program has been implemented and evaluated, there remains a lack of comprehensive evaluation data. Evaluations to date have provided some evidence that this program holds promise in changing police attitudes toward persons with mental illness and police perceptions of self-efficacy in responding to mental health calls, reducing arrests, and improving linkage to services (Compton, 2006, 2008; Canada, Angell & Watson, 2010, 2011), less use of force with more resistant individuals (Watson et al., 2011), Canada, K. E., Angell, B., & Watson, A.C. (2010). On a multi-year before and after analysis of dispatch records, Teller, Munetz, Gil, and Ritter (2006) found significant increases in identified mental health calls, as well as increased transports to hospital as well as increased voluntary transports.

The limitations of this model may include the potential costs of implementation as it includes development of two types of training (officer and dispatch) and development of selection procedures and criteria, although guidance is available through CIT International and the Consensus Project website to assist. Maintaining levels of available CIT officers, including potential costs due to job movement within the police agencies, and the time, energy and resources necessary to maintain program fidelity can sometimes be a challenge as well, particularly for smaller police agencies.

Interdisciplinary Crisis Intervention Team Program

This model is the same as the CIT model described above, but training is an interdisciplinary community-based model, which includes relevant partners from other sectors, including mental health, hospitals, community service and advocacy providers, Emergency Health Services (ambulance), and Fire Department. The intention here is to

develop a true community team, ensuring that partners receive the same information and are on the same page, to improve cross-sectoral knowledge on mandates, experiences, limitations, and policies that may affect interactions between partners. Each sector or agency designates a liaison to a team which continues to meet regularly after training to maintain partnerships, troubleshoot issues with response and service provision, and build solutions for gaps that may exist within the service response continuum. This model has been implemented and sustained in Prince George, B.C. since 2006. A 2015 evaluation provided generally positive qualitative results in an unpublished Masters thesis (Bumby, 2015). The primary positive result was improved understanding, collaboration and coordination among police and other services providers, resulting in improved service provision to persons with mental illness in the community.

The potential limitations of this model include capacity issues of different agencies to participate, challenges in gaining and sustaining commitment from a wide range of partners, backfilling costs/availability for the 40-hour training commitment for participants, and turnover within a range of agencies.

Summary of Police Crisis Intervention Models

This brief outline of some of the most common models of response shows some of the promising elements and limitations to be considered when developing a program for police response to emotionally disturbed persons. Unfortunately, the empirical research and comprehensive evaluation of these models of police response to EDPs are extremely limited (Morabito, Kerr, Watson, Draine, Ottati & Angell 2012; Watson, Morabito, Draine & Ottati 2008). Going forward, any plan for development of a program should include a

comprehensive plan for evaluation from the outset in order to provide an evidence base of the effectiveness of the program.

Building the Best Model for a Community

Planning for development and implementation of an effective model of response to emotional and behavioural crisis is imperative and choosing a model that fits the community's specific needs and assets provides the best chance of success. This requires a process of information collection, collaboration development, research, and an implementation plan as well as a plan for sustainability. Below are some recommended steps to assist communities interested in developing and implementing a model for police intervention with EDPs based on evidence from research and evaluation.

Community Needs and Capacities Assessment

Models that work well in one location will not necessarily transfer over successfully to a community with different needs and resources. As such, many community-based factors must be considered at the outset of development of a model. A community needs assessment will involve some combination of research, meetings, interviews, surveys, focus groups, and public fora with a variety of sectors to determine the needs and limitations within the community which will influence whether a model should be developed and what would work best in the community.

Before starting a needs assessment, there must be a clear vision of the focus – including a conceptual model, if possible. Conceptual models or logic models vary based on the subject matter, but a community readiness model (Edwards, Jumper-Thurman, Plested, Oetting & Swanson, 2000; York, Hahn, Rayens & Talbert, 2008) might be particularly

appropriate in this context. This model, as described by Edwards et al., provides nine levels of examination and strategy to ensure that a community is sufficiently prepared for the successful development and implementation of the proposed change or program. The nine levels include: awareness, preplanning, preparation, initiation, stabilization, confirmation/expansion, and professionalization.

Relevant considerations for investigation and reporting include the size and location of the community, population, demographics, and potential stakeholders and resources within the community. The latter will vary from community to community, as will their capacity and commitment. While not a finite list, sectors which should be canvassed will likely include the following:

- police and associated agencies;
- hospitals;
- emergency responders including EHS (ambulance) and Fire Department;
- mental health services – public health and community-based;
- probation and parole;
- diversion programs;
- persons with lived experience and their family members and advocates;
- dominant minority racial and cultural communities;
- potential academic contributors/partners;
- government (municipal and/or district);
- potential funders; and
- other identified stakeholders as appropriate.

The assessment is an overview of the community and its needs for the program, as well as any impediments or limitations that may be identified in relation to, for example, capacity, commitment, policies, and engagement. The purpose is to have a comprehensive view of the context in which the program will be developed, the identification of assets and supports that will assist development, and of impediments or limitations which need to be overcome. This will also inform timelines: it is important to determine whether the community is ready to proceed, or capacity building is necessary to support an effective and sustainable program (Saunders & Marchik 2007).

Research/Knowledge of Current Best and Promising Practices

This area of knowledge and experience is changing and growing with the development of new models, as well as with evaluations of those that are currently functioning. It is important to research and review the state of knowledge in the area before making a commitment to a model or developing a new model. Knowledge of what has worked in which contexts is important for the model to have grounding in best and promising practices in this area. While there is a current paucity of comprehensive evaluation findings for programs of this kind, this will hopefully improve with time. In the meantime, one of the best starting points for research in this area is the Criminal Justice/Mental Health Consensus Project, a national project coordinated by the Council of State Governments in the U.S. (https://csgjusticecenter.org/mental-health-projects/report-of-the-consensus-project/). While now over 15 years old, this compendium covers the intersections of mental health across the criminal justice continuum in collaboration with a wide range of relevant sector specialists. Updates and further information is available through the website of the Justice Center of the Council of State Government, as noted above.

Commitment and Leadership

One of the primary elements in successful program development, implementation, and sustainability is commitment and leadership from the top levels of agencies to be involved in the program, including active endorsement and promotion within and outside of the agency, and commitment to collaboration. Without leadership buy-in, any program is vulnerable. Part of effective leadership is ensuring that not only is there commitment from the top levels, but also from the front lines; a unity of perspective and commitment is necessary for effective change (Masal, 2015).

Planning and Implementation: Focus on Collaboration

The planning and development of a response model is best accomplished through development of a vision and mission that is informed by a collaboration which includes *inter alia* a variety of sectors, including mental health, emergency services, hospital(s), persons with lived experience and/or their advocates, and academic specialists in the area. General desired outcomes should be identified to assist in model selection and planning. Collaborative strategic planning can be time consuming, especially with sectors which have different and sometimes competing interests but addressing these at the outset can prevent or limit issues from arising at a later date. A comprehensive strategic plan which addresses identified issues can provide a solid base for success.

Model Selection and Plan

Selection of a model will be informed by the needs assessment, the strategic planning which provides the vision and mission, and the research showing elements of best or promising practice. The model should be as comprehensive as possible with a view to the

continuum of service involvement – from first call (call taker and dispatch), to police attendance, to hospital transfer or diversion or (if necessary) arrest and jail. At each point in the continuum the needs, limitations, service availability, and desired outcomes for both the individual and the service provider must be considered and addressed in the best way possible within the constraints of what is possible. Limitations should be identified for response and improvement where and when this is possible.

Evaluation Planning

Program evaluation is imperative to determine program effectiveness in three main areas: implementation, process, and outcomes. The process for developing an effective and appropriate evaluation plan can be complex, usually involving the development of a logic model (which is also useful for program development), choice of a research design and evaluation strategy including the development of measures, methods and instruments for data collection and analysis (McDavid, Huse & Hawthorn, 2013). Evaluative evidence provides guidance on what is working and what is not and provides necessary information for course correction to address barriers or issues, to improve efficiencies, and show outcomes. Evaluations are almost always limited; rarely are there sufficient data and resources to conduct a perfect evaluation. In the criminal justice arena, additional limitations may arise due to the sensitive nature of the data, human error, and ethical considerations. These issues must be considered and taken into account when developing an evaluation.

Evaluation must be a front-end consideration, with the development of an evaluation plan including determination of what data needs to be collected, how and by whom it will be collected, where it will be stored, who will be analyzing and reporting on the evaluation

data, and to whom (McDavid et al, 2013, p. 163). Early identification of evaluation needs and systems ensures accurate and comprehensive data collection from the outset, providing solid evidence for evaluation.

Once categories of required data are identified, systems must be in place to collect it; if they do not exist, they must be implemented. The first category of data for consideration is baseline data that reflects the pre-program context. If there is no baseline data available for comparison with post implementation outcome data, other means must be established to determine program impact. A comprehensive evaluation should also capture more than data related to goal outcomes, anticipating the possibility of unintended outcomes or collateral impact. Potential confounding factors should be identified and minimized so that causal relationships can be ascertained as clearly as possible. Privacy and security issues respecting personal and sensitive information must be identified and addressed. Ethics issues should be given consideration, particularly in engagements with vulnerable persons.

The two most common types of evaluation data are quantitative and qualitative. Quantitative data generally relates to usage and outcomes of the program and should include such data as numbers of encounters, origin (for example dispatched calls, casual encounters, stop-and-check, or other), types of encounters (for example mental health only, disturbance, minor crime-related, major crime related), processing times (on scene and outcome related – for example return to home, informal disposition, hospital admission, booking), and outcomes (for example informal resolution, *Mental Health Act* apprehension, diversion from criminal justice, and arrest). In a program of this type, "usage" is different than in a program where individuals may choose whether to engage in the program or not; if the program is the mandated response to mental health crisis, there is less or no choice.

Usage is still a relevant measure in these programs, however, to show adoption of the program within the police agency as well as reflecting need for the program.

Qualitative evaluation in this context may focus on how satisfied both stakeholders and clients are with the program both in terms of process and outcomes, including perceptions of treatment by police and program partners. This type of evidence is generally collected through surveys, questionnaires, individual interviews, and focus groups. Relevant persons/groups as sources of feedback may include police officers, mental health service providers, hospital personnel, persons with mental illness and family members/advocates, and the public. Topics may include quality and effectiveness of implementation, process, relationships, reach, and collaboration, as well as identification of barriers, limitations and necessary improvements.

Independent evaluators are preferred to ensure evaluation results are, and are perceived as being, objective, professional, and unbiased, as well as having the expertise to construct a methodologically robust and trustworthy evaluation strategy. Where professional evaluators may be beyond the financial capacity of the community, one option may be to engage an educational institution such as a university to develop and implement the evaluation; this can provide a less expensive yet professional and objective evaluation with full consideration of ethical issues. The benefit to the university is access to data and information for academic knowledge and publications, as well as training of the next generation of practitioners.

Officer Selection

Where a community is considering or has identified a Memphis CIT or a mobile response program with specialized response officers as the best option for them, officer

selection processes are integral to the quality of a program. Not every officer has the characteristics and background to do this work well. An exaggerated police perception of the danger to themselves in these encounters, as referenced earlier (Morabito & Socia 2015), can be a barrier to effective non and less lethal response. These issues can be ameliorated to some degree through basic training for all officers but can be further reduced through careful selection of officers at the outset.

Selection of program officers is under-studied to date yet is potentially highly relevant in the success of a police crisis response program. While training is important for all personnel, personal characteristics that enhance performance in crisis response for EDPs are likely very relevant to success. There is little research on the factors that make good crisis response officers, although it is often assumed that previous positive experience with this population from either a personal or professional viewpoint and exposure to the mental health field is a factor which reduces stigma and social distance. Such a background also tends to provide better knowledge and understanding of the experience of mental illness, a good base for further training and successful performance. There is some evidence that college educated officers have a significantly reduced likelihood of using force (Rydberg & Terrill 2010; Terrill & Mastrofski 2002), and that within general populations previous contact with persons with mental illness reduces stigma and social distance (Couture & Penn 2003).

Two areas of selection have been identified as having some potential impact on success: officer self-selection and consideration of screening criteria.

Volunteer/Self Selection

While it is often recommended that self-selection is an important component in the Memphis CIT model, where it is listed as a core component (Dupont, Cochran & Pillsbury, 2007), the potential value of volunteering remains largely untested (Compton et al., 2017). While there is some evidence that self-selected CIT officers are more likely to have been exposed to mental health professionals, they do not significantly differ from other officers in empathy or psychological mindedness before their training (Compton et al., 2011). A recent study was the first to investigate differences between voluntary versus assigned CIT members (Compton et al., 2017), and it found that volunteering for CIT is associated with sustained positive outcomes in attitudes (lesser personal responsibility attitudes and anger towards suicidality and greater helping attitudes toward someone in psychosis), de-escalation skills, and referral decisions (fewer arrests and more referrals to treatment). This study did show one anomaly: a greater likelihood of volunteer officers to use force. This may be due to inclusion of "handcuffs" in the definition of force; handcuffing is a common police practice, and sometimes policy mandated, when transporting a person to hospital for psychiatric assessment. It would be helpful to investigate whether rates remain the same when handcuffing is excluded from the definition of force.

Pre-Selection Screening

Psychological testing is common in the selection process for police recruits and can likewise be useful in selection of officers for crisis intervention programs. Assessment of aggression and behaviour control may be particularly relevant considering findings of the prevailing assumption among police that encounters with mentally ill persons are dangerous (Morabito & Scolia, 2015). Koepfler, Brewster, Stoloff and Saville (2012)

investigated the possibility of testing for potential aggression through indicators of "hostile attribution bias" which is a tendency to attribute hostile intent to ambiguous behaviour or motivations (especially relevant in relation to encounters with mentally ill persons), and of impulsiveness, or lack of behavioral control, particularly aggression. This study provided some preliminary evidence that the Monetary Delay-Discounting Task (MDDT) test was the only test which appeared to be effective at predicting behavioural control and aggression among a set of police officers; this might be a useful tool in the selection of officers to work in this area of police work, although further research would be beneficial.

Personality, communication styles, and perceptions of procedural justice during police interactions with community members are relevant for police work generally, and with the mentally ill population in particular. The way an officer communicates has a significant influence on how the interaction will play out; studies have found that perceptions of procedural justice – interpersonal treatment and quality of officer decision-making – improve compliance, respect, and cooperation (Dai et al. 2011; Sunshine & Taylor 2003; Tyler, 2003). The important role of procedural justice in police encounters is now widely recognized. A meta-analysis of studies from Australia, England and the U.S provides strong evidence that police behaviour perceived as "procedurally just" – treating people with dignity, respect, fairness, hearing their voice, and being transparent and trustworthy – can have a significant positive effect on police-community relations: increased confidence, compliance, cooperation, and legal obedience – police gain legitimacy with and in the community (Mazerolle et al. 2013). This is particularly important to vulnerable populations such as the mentally ill, according to several studies focused on perceptions of people with mental illness about police (Watson & Angell 2007; Livingston et al 2014) and particularly

during a mental health crisis or arrest, leading to better responses and compliance (Watson & Angell 2013).

Testing done at recruitment could provide information on personality characteristics that are important in successful mental health-related interactions, including empathy, lack of aggression and neuroticism, behavioural control, communication skills, and procedural justice approach to interactions. Most police agencies conduct personality testing at recruitment; the Royal Canadian Mounted Police (RCMP) use one of the most popular tests, the Minnesota Multiphasic Personality Inventory-2-RF (Tarescavage, Gupton & Ben-Porath 2015; Private communication: RCMP National Recruiting Program Jan 10, 2018). If recruitment test results are old or unavailable, new testing is recommended to determine the current status and skills and weaknesses of the officer. The MDDT may provide particular insight into aggression and behavioural control. Psychological testing should focus on findings of high levels of empathy and low levels of neuroticism which appear to predict procedurally just behaviour in interactions with community members (Lawrence, Christoff & Escamilla, 2017).

There is one further area of testing that should be further investigated for potentially more reliable outcomes than psychological testing. Researchers have begun to assess the possible value of physiological measurements to assess its potential for predicting post- traumatic stress disorder and capacity for trauma resilience, as well as behavioural control, which might impact officer performance and use of force decisions. These dynamic measurement studies are based on measuring the levels of certain biological chemicals, skin conductivity (sweat tests), or eyeblink (startle) response to stressors (Salters-Pedneault, Ruef, & Orr, 2010).

A recent meta- analysis compared the validity of a range of testing factors, including pre-existing psychopathology, pre-employment trauma history, physiological factors (individually cortisol, biologic chemistry, skin conductivity, and startle response), personality factors, coping styles, and social factors, in order to assess their ability to predict mental health outcomes of emergency workers (Marshall et al., 2017). While this study looked at the impact on the mental health of a range of emergency workers, the outcomes were interesting. The highest rate of predictivity of PTSD came from skin conductance/startle response and coping styles, followed by personality factors and cortisol levels. Overall it appears that physiological measurement provides a stronger and more reliable measure for future outcomes than does personality inventory testing - at least in respect to officer mental health.

Related research by Salters-Pedneault et al. (2010) shows some interesting physiological factors common in police recruits. While firefighter recruits had a higher baseline level of heart rate and skin conductance, police showed higher startle responses (eyeblink electromyogram) and required more time to return to a normal state. This is particularly relevant in the policing sector, where startle response may result in startle reflex, which can be problematic when weapons are involved. In this respect, physiological reaction also has the benefit of being controllable: research has shown that police physiological response control can be taught, leading to better use of force decisions (Andersen et al, 2016). Police agencies would benefit from further investment in physiological testing, which has better predictive rates than most other testing models. Physiological testing, while being more expensive and intrusive, has the benefit of being

much more difficult to fake or control, contributing to an increased predictive capacity, and is particularly relevant to use of force issues.

Training

Training is probably the most studied element of police response to mental health crisis, primarily the impact of CIT style training on police officers' knowledge, skills, and attitudes. Evaluations of the impact of this training indicate that officers report a better understanding of mental illness and a greater sense of confidence and self-efficacy in dealing with EDPs (Bahora, Hanafi, Chien & Compton, 2008; Borum, Deane, Steadman & Morrisey, 1998; Kubiak et al., 2017; Tully & Smith, 2015) and that CIT training minimized the level of force used in EDP encounters and reduced civilian injury (Bower & Pettit, 2001; Morabito et al., 2012; Skeem & Bibeau, 2008).

The main components of training of police officers in crisis intervention are similar in most cases and is based on the Memphis CIT model. The U.S. Department of Justice Community Oriented Policing Services (COPS) office is expected to release a model curriculum for this training soon (Watson, Compton & Draine, 2017). CIT International has developed a curriculum containing the core elements (outlined below), although the details of some elective components are based on community needs and regional variations. A sample CIT syllabus from Ohio is provided at Appendix A, and a copy of the National CIT curriculum is provided in the Watson et al. (2017) article (p. 433).

CIT training include modules on:

- Severe and persistent mental illnesses;
- Thought and mood disorders;
- Substance abuse issues and co-occurring disorders;

- Personality disorder;
- Cognitive disorders (dementia, delirium);
- PTSD;
- Suicide;
- Assessment and committal: law, requirements, and processes;
- Community resources and collaborations;
- Advocacy perspectives;
- Social distance reduction/interaction with persons with mental illness; and
- Crisis Intervention and De-escalation approach and communications (including participatory scenario practice).

These pieces are intended to provide training participants with a background knowledge that promotes a better understanding that mental illness and associated behaviour is not a choice, teaches officers the best approach and skills to de-escalate crisis and "humanizes" the experience of people with mental illness, thereby reducing social distance and fear.

The literature suggests crisis intervention training might benefit from the following additions:

a. *Addressing myths* – as noted above, police officers tend to perceive persons with mental illnesses as particularly dangerous, a perception not borne out by the evidence currently available; from the bare numbers, police are much more likely to kill a person with mental illness than be killed by one. Reducing officer fear and increasing understanding of defensive behaviours resulting from hallucinations or delusions and prior victimization may help officers approach the interaction with less fear and greater compassion. Another myth mentioned above is that the

behaviours exhibited are a choice, rather than a consequence of illness. An interactive session with officers on what they believe to be true and what is actually true would be useful.

b. *Physiological Control* – The evidence indicates that a significantly high number of police shooting deaths (and possibly use of force incidents also) involve persons with mental illness. It would be helpful to include in the training a component on physiological control to reduce use of force incidents, like the International Performance Resilience and Efficiency Program (iPREP), for which there is some evidence of effectiveness in improving use of force decision-making through the calming of physiological effects during stressful situations (Andersen 2016). While similar to mindfulness training, the particular mindset of police might be more amenable to training focused and labeled as physiological control.

c. *Procedural Justice* – The studies investigating perceptions of persons with mental illness about their encounters with police have emphasized the value of procedural justice elements in these encounters, in a few ways. Treating individuals, (particularly vulnerable individuals) respectfully and fairly, hearing them, being transparent and trustworthy, and collaborating in solution-building improves their perception of police generally and may result in better outcomes in this and future encounters. Significant from the police perspective, procedurally just behaviours also help to achieve compliance, cooperation, and resolution. The benefits extend to the community as well, improving respect for police and improving their reputation in the community.

d. *Reducing social distance/addressing stigma* – Training participants may find this the most notable part of the training, as it provides a different view for police who may only see mentally ill individuals when they are in crisis. The impact of this component is to humanize individuals who live with mental illness and provide an opportunity for police to interact with people when they are well and not in crisis. Site visits to mental health clubhouses and informal interaction with persons with mental illness are recommended for a more casual atmosphere; one possibility is a mental health clubhouse "hosted" lunch or coffee where people can talk with police about their lives and experiences of living with mental illness. Another common format is a panel of consumers (persons living with mental illness) and family members who provide stories of their experiences and engage in an open question and answer period.

e. *Cultural/Immigrant/Refugee component* – Understanding the effects of migration generally and the experience of being a refugee and the impact on mental health as discussed above is one facet of this component. In addition, it is important for officers to be aware of cultural values, differences, and perspectives on mental illness of immigrants, refugees, or indigenous communities prominent in the community in which they work. Building relationships in and with these communities will provide a basis of trust and respect which will benefit future interactions with members of those communities when in crisis.

f. *Community Collaboration* – Memphis CIT emphasizes community collaboration as an important element of that model, and it is an important element in any response model to crisis. To be effective and efficient, police must develop strong

relationships with mental health services, hospitals, as well as advocates and community service providers. Included in the above outline of core components is "community resources and collaborations". While it is imperative for officers to understand what resources exist in the community, they must be able to develop collaborations to enhance the processes they engage in when dealing with crises. Collaborations do not always develop on their own and providing some guidance for developing and/or maintaining these collaborations and overcoming obstacles may provide the tools they need to do so.

g. *Diversion* – Once a crisis is de-escalated, officers need to consider what the disposition options are with respect to the individual involved. The basic options usually available are return to home, transport to hospital for assessment, or arrest, but these are not always the most appropriate options. Police need increased awareness of other diversion options in the community, such as short stay crisis beds, peer support services, and other options for officers to divert the individual from jail and engagement in the criminal justice system where appropriate. This is somewhat different than just a review of resources in the community; it entails a review of the criteria, processes, requirements, availability, and limitations of these options to provide officers with the knowledge needed to determine the best option for diversion in a particular situation.

There are two additional areas meriting discussion in this review of training: the place and role of dispatchers, and the delivery of training.

Dispatch

The important role of dispatch in the continuum of care is sometimes overlooked, yet this is the starting point of police engagement and may be highly influential over how an officer will approach the encounter. The ability of a dispatcher to knowledgeably assess the information from a call, ask the right questions to obtain important information, and relay that information to the attending officer can make a significant difference. Research indicates that dispatch coding and information can affect who is dispatched to a call, how an officer responds to a call, and also their decisions as to disposition (Ritter et al., 2011). A call-taker who can elicit information from the call about the circumstances, including signs of emotional or mental health disturbance and behaviours, and transmission of this information in the dispatch can result in very different approaches. If the call goes out as a potential assault or threatening person rather than an EDP call because the call-taker has not obtained relevant information, attending officers may take a more aggressive stance. Coordination of calls from different members of the public also need to be coordinated to determine the likelihood of the calls relating to the same individual, and assessment of the quality of information from callers is also important.

The training of call-takers and dispatchers on the identification of mental health symptoms and behaviours would assist them in being better able to assess the information received, to ask the right questions to elicit the most accurate and useful information which they can then provide to attending officers; cross-training with officers during relevant sections of mental health training would be beneficial (Sheehan, 1995); use of the same terminology and a common understanding of relevant information creates better understanding and communication. Additional training on and use of a flowchart or

flipchart would assist call-takers and dispatchers in determining what questions to ask to elicit the information needed.

Training Delivery

Some police agencies consider the cost of training to be prohibitive, and some agencies develop and provide training from inhouse psychologists and officers. Although there has not been substantial evaluation of the methodology of crisis intervention training, there are some indicators of preferential models that both reduce costs and provide benefits.

First, a training model which based on co-facilitators – one from police and one from mental health – provides some balance between the different perspectives and helps to prevent bias towards one or the other. This also endorses the collaborative response model proposed as a beneficial element. Secondly, training providers (presenters) are best selected from local agencies; this provides connections and promotes relationship building at the local level and reduces costs as these presenters will usually develop materials and present as part of their professional or work responsibilities without extra charge.

Conclusion

The issues involved in police response to emotionally disturbed persons and persons with mental illness are complex, and not easy to sort. Even defining and measuring these interactions is challenging, since police are not in the business of diagnosing mental illness but rather responding to behaviours which are problematic from a societal perspective. Yet responding as respectfully and effectively as possible in these encounters is important to the people they are engaging with, to society, and to themselves.

Improving these responses requires a better understanding of the people that they are encountering, the potential reasons for increasing rates of such encounters, the nature of behaviours as involuntary, and police behaviours that will elicit trust and compliance rather than fear and resistance on the part of the person in crisis. Knowledge, experience, collaboration, and empathy are all factors which will improve police responses in these encounters.

Development of a comprehensive program for effective police response to emotionally disturbed persons requires preparation, planning, and relationship building at the community level. Best results are not achieved through a siloed approach but rather a collaborative approach. It does take time and effort, but better results are achieved through a careful and thorough development process than trying to "drop in" a model that has developed and has worked somewhere else. Knowing the needs and assets of the specific community as well as what research tells us about effective approaches and relevant factors, basing a program on best or promising practices, and preparing for ongoing evaluation in order to address issues and make course corrections, is imperative to developing an evidence-based program that fits the community and has the best prospect for improving outcomes.

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Appendix A

DATES TIMES	Monday	Tuesday	Wednesday	Thursday	Friday
0800	Class	Developmental	Age Related	Non-Psychiatric	Site Visit:
	Introduction	Disabilities	Disorders	Behavior	
0830					Scenario Training
					and Evaluations
0900	Introduction to	Substance Abuse /	Suicide	"Voices" Simulation	
	Clinical Disorders	Co-Occurring Disorders	Assessment		Simulation Site
0930					
1000					
1030					
1100	Intervention Strategies #1	Children's Issues	Civil Commitment Laws /	CIT Procedures	
			Liability Issues		
1130					
				CIT Staff	
1200	Lunch	Lunch	Lunch	Site Visit:	
1230				Lunch with Consumers	Lunch
				Day Treatment Center /	
1300	Personality Disorders /	Site Visit:	Site Visit:	Mental Health Clubhouse	
	Borderline Personalities				
1330		Emergency Procedures	Consumer Contact	Site Visit:	Family and
		/ Consumer Contact	Utah State		Consumer Perspective
1400		Local Hospital	Hospital	Intervention Strategies #2	
				Theater Location	
1430					
				Scenario Training	
1500	Psychotropic Medications	Site Visit:			Questions &
					Answers
1530		PTSD Session			State Exam /
		/ Consumer Contact			Graduation
1600		VA Site			
1630				Test Review	
1700	END	END	END	END	END